Specialist Palliative Care Consultation Service

Comfort Care Bundle for the Frail (CCBF)

A support program for patients on a longer end-of-life pathway who prefer to be cared for in the home, in a residential aged care facility or other community care settings.

Program overview

The Comfort Care Bundle for the Frail (CCBF) is a specialist palliative/geriatrician consultation service which provides integrated solutions to fill the gap that exists for people in the Metro North Health catchment who have life limiting illnesses, advanced frailty, and/or cognitive and functional decline.

These patients would like to decrease hospital presentations and focus on comfort care/symptom management. The service sits beside SPACE under CPC and works in conjunction with those teams to capture those patients for specialist symptom management and advanced care planning who do not yet meet the criteria for CPC, SPACE or Palliative OPD as their prognosis may be much longer than the usual three-months.

The aim of CCBF is to ensure that patient and/or carer wishes are documented and respected, and to reduce the impact of care on the Metro North Hospital system. These patients can be streamed to more suitable venues for their care including home, palliative care, subacute care and residential aged care.

Community based options for end-of-life care will be planned for these patients. This service provides structure for those already in a Residential Aged Care Facility (RACF) and those looking to transition into aged care for patients who no longer want restorative care.

CCBF addresses one of the major gaps perceived by acute care clinicians who recognise the subacute needs of their patients but require support to attend ACP/GOC, symptom management, and EOL planning.

Referral pathways

- Use REFER for internal referrers. Metro North Health paper referrals are available on the Metro North QHEPS site at Community Palliative Care Service | Home hospital | Community and Oral Health and can be submitted through the central referral unit. Note that CCBF is required.
- Ward consultation is available in all Metro North Hospital and Health System catchments, both in the Acute and Non-Acute settings via verbal referral and followed by eREFER.
- RACF consultation is available to all RACF's in the Metro North catchment.
- GP's can refer through 'Refer your Patient' or 'GP Smart Refer' online systems. Just note that referral is for 'CCBF.
- Community home-based consultations are also available.

Referral criteria

Inclusions:

- The cognitively and physically frail, whose focus is on comfort care and hospital presentation prevention.
- Prognosis is usually longer than three months.
- Situated in any Metro North Health acute inpatient, bedded service, RACF or community home setting.

**For patients sitting outside the inclusion criteria, referrers can contact the CCBF team to discuss eligibility.*
***For patients within the three-month prognosis, referrals can go to SPACE or CPC.*

The CCBF team

The service is made up of specialist palliative and geriatric medical consultants who undertake the initial assessment in the acute facilities, RACF or home as well as the follow up in the community after discharge. They are involved in patient assessments, patient and family consultations and Advanced Care Planning. They also provide the point of contact for all palliative care / end of life clinical escalation requiring medical intervention.

The team also includes a clinical nurse consultant (CNC) and registered nurses. The CNC provides clinical liaison between acute hospitals and the RACFs to reassure that appropriate ceilings of care have been discussed, and the necessary supports are in place when the patient starts dying. The CNC is also available for follow up phone calls with community home based patients/carers/family members. The CNC triages and processes all referrals and attends a first point of contact with the GPs and EPOA's to gain permission to consult.

The registered nurses complete RACF and home visits and phone reviews and have key responsibility in supporting the RACF in care delivery, education on deterioration/symptom management/supporting GOC, and therefore achieving hospital avoidance.

Contact details

(07) 30495737 | P: (07) 30491226
CPC-CCBF@health.qld.gov.au
metronorth.health.qld.gov.au
Level 1, 9 Endeavour Boulevard
North Lakes Health Precinct
North Lakes, QLD, 4509

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